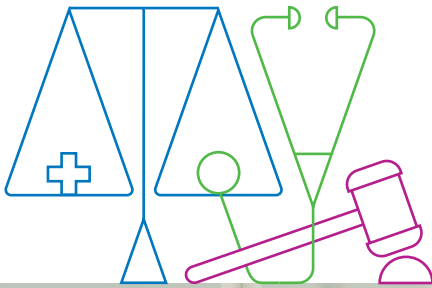


ANESTHESIA SPECIALTY OVERVIEW



ANESTHESIA CASE STUDY

A thorough anesthesia assessment is needed to confirm the ASC setting is appropriate for the patient.

Initial criticisms were centered around the lack of documentation.
Additional criticisms were centered around the lack of preparedness.

Brief Facts

- Patient presented to an ambulatory surgery center (ASC) for elective laparoscopic gastric band (LAP-Band) system insertion and possible hiatal hernia repair.
- Anesthesiology completed pre-op anesthesia assessment the morning of surgery.
- Patient assigned Mallampati Class III and ASA Class III.
- EKG recorded with no time or date in the record.
- At 10:00 a.m. anesthesia was initiated with sevoflurane gas, propofol, fentanyl, dexamethasone, and rocuronium. Intubation was eventually successful on the fourth attempt.
- Bariatric surgeon performed the LAP-Band procedure without complication.
- The intraoperative anesthesia record listed patient's oxygen (O₂) saturation (sat) and end-tidal carbon dioxide (ETCO₂) concentrations to be within normal limits throughout the procedure, which was completed at 10:40 a.m.
- The extubation time was not documented, but nursing notes indicate the patient arrived in the post-anesthesia care unit (PACU) at 10:55 a.m. with a dusky appearance and shallow breathing.
- At 11:00 a.m. a bag valve mask (Ambu bag) was utilized by the anesthesiologist in PACU to assist with the patient's breathing. O₂ sats were noted to be 85 at the initiation of these efforts, which reportedly continued for about an hour and a half.
- At 11:30 a.m. anesthesiology notes reflected an O₂ sat of 84, while nursing notes reflected an O₂ sat of 78.
- At 11:45 a.m. the anesthesiologist inserted a laryngeal mask airway (LMA), at which time the nurses began to assist respirations with an Ambu bag.
- At 11:48 a.m. the anesthesiologist suspected the LMA was leaking and replaced it. Nursing notes indicated that pink, frothy sputum was suctioned from the patient's nose and mouth at this time.
- At 11:50 a.m. intravenous (IV) furosemide was administered, and a Foley catheter was inserted with a resultant 100 cc of amber urine.
- At 12:00 p.m. O₂ sats remained in the mid-80s, prompting administration of IV dexamethasone followed by albuterol.
- At 12:30 p.m. the patient was noted to be tachycardic and diaphoretic, and his skin color appeared bluish.
- The anesthesiologist removed the LMA and reintubated the patient. He was transported back to the operating room (OR) where he was ventilated and attempts to transfer the patient to a higher level of care were initiated. (The anesthesiologist would later testify that he did not have the authority to transfer the patient and relied on the ASC to facilitate it.)
- The patient remained sedated on the ventilator in the OR under the anesthesiologist's care awaiting transfer for five hours.
- At 5:30 p.m. emergency medical services (EMS) arrived, and the ASC staff assisted with the patient's transfer from the bed to the gurney and into the ambulance.
- Upon loading him into the ambulance his cardiac rhythm converted to asystole, and paramedics initiated advanced cardiac life support.
- The patient was rerouted to the nearest hospital emergency department where life-saving efforts continued. He passed away shortly after arriving at the hospital.



Allegations

Negligent anesthesia management for LAP-Band surgery resulted in post-operative cardiopulmonary arrest and death.

Expert Testimony

Both plaintiff and defense experts were unsupportive of multiple aspects of the anesthesiologist's care.

Pre-Operative Evaluation: Initial criticisms centered around the lack of documentation of a thorough pre-operative evaluation and physical exam, including review of pre-operative consultations, to ensure readiness for surgery in an ASC setting.

Documentation: Review of the surgeon's medical record documentation revealed a more complex medical picture than what was reflected in the anesthesiologist's documentation. Pertinent additional diagnoses included hypertension, obstructive sleep apnea, hypercholesterolemia, gastroesophageal reflux disease, depression, steatohepatitis, and chronic bronchitis. With the additional information, experts agreed that the patient's ASA classification would have changed and required a hospital surgical setting.

Lack of Preparedness: Experts opined the anesthesiologist was unprepared to handle a difficult airway, which affected this patient at multiple stages of care including the initial intubation, the LMA placement in PACU, and the subsequent intubation when the patient continued to decline. Experts also opined that both the anesthesiologist and ASC were unprepared to manage patients requiring a higher level of care as there was no transfer agreement in place with any neighboring hospitals. There was also confusion regarding whose responsibility it was to initiate the transfer and ensure that it occurred in a timely manner. Experts agreed that a more active approach should have been taken to transfer the patient to a higher level of care when he met the definition of being critically ill, requiring mechanical ventilation. They opined that EMS should have been called at that point, as the patient's status would have required neighboring hospitals to accept the patient even without a transfer agreement in place.

Complicating Factors

Excess Verdict Risk: As with any unexpected outcome such as death, there are concerns around the potential for an excess verdict.

Transfer Agreement: No formal transfer agreement with a local hospital and the inability to initiate transfer was difficult to defend.

Lack of Preparedness: The anesthesiologist was unprepared to handle a difficult airway.

Missing Documentation: Poor documentation throughout the delivery of care left many aspects of the anesthesiologist's decision-making unclear and complicated the defense of the case.

Resolution

Settlement reached: The case was settled due to a number of complicating factors such as lack of preparedness and missing documentation.

Risk Reduction Strategies

Patient Selection

- Develop policies and procedures that define patient selection criteria protocols especially for ambulatory setting.
- Develop clinical pathways to ensure consistency in approach to determining readiness for surgery.
- Determine exclusionary criteria or contraindications requiring referral to the inpatient surgical setting, based on your center's capabilities.
- Avoid making exceptions to your policies and procedures regardless of a patient's desire to accept additional risks that may apply to their unique medical picture.

Pre-Operative Assessment

- Ensure there is a well-documented pre-anesthesia evaluation performed or verified by an anesthesiologist within 30 days of surgery.
- Ensure the patient receives pre-operative instructions and has an opportunity to ask questions.
- On health questionnaires, consider specifically inquiring about medical conditions that may increase risk of complications. If sections are left blank, discuss these further rather than assuming a negative response.
- Ensure pre-operative testing, including medical clearances, is ordered, obtained, and reviewed prior to the day of surgery.
- If there are any changes in the patient's pre-operative medical history or unexpected physical exam findings on the day of surgery, postpone the procedure. Obtain the necessary tests or records required to ensure it is safe to proceed.
- Understand and follow ASA guidance on the basic standards for pre-anesthesia care.

ANESTHESIA CLAIMS DATA & INDUSTRY TRENDS

ProAssurance is a contributing member of the Medical Professional Liability Association (MPLA) closed claims data sharing project. As such, the general data listed below includes claims data showing industry trends specific to anesthesia-related claims from 2012 through 2021. Using this information, our Risk Management department can target specific areas of anesthesiology practice to deploy risk mitigation strategies and resources.

How Does Anesthesiology Compare to Other Specialties?

Anesthesiology ranked 7th highest for total indemnity out of all specialties, with \$325.1 million.

Anesthesiology ranks 10th highest for average indemnity, with \$394,530, 8th for closed claims, and 8th for paid claims.

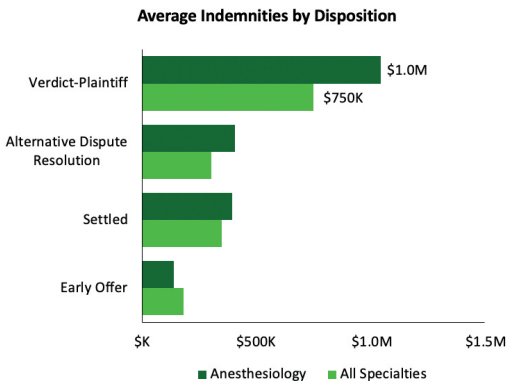
The largest indemnity Anesthesiology saw was \$4,673,379.

	Closed Claims	Paid Claims	Average Indemnity Paid	Total Indemnity Paid
Radiology	5,337	1,583	\$401,576	\$636 Million
Anesthesiology	3,012	824	\$394,530	\$325 Million
Internal Medicine	7,434	1,694	\$382,882	\$649 Million
Emergency Medicine	2,139	520	\$371,334	\$193 Million
General Surgery	5,492	1,650	\$356,098	\$588 Million
Family Medicine	5,193	1,601	\$321,514	\$515 Million

Average Indemnity by Disposition: Anesthesiology vs. All Specialties

The average indemnity for Anesthesiology plaintiff verdicts was 33% higher than other specialties.

Anesthesiology exceeded the All Specialties average for all resolutions except early offers.

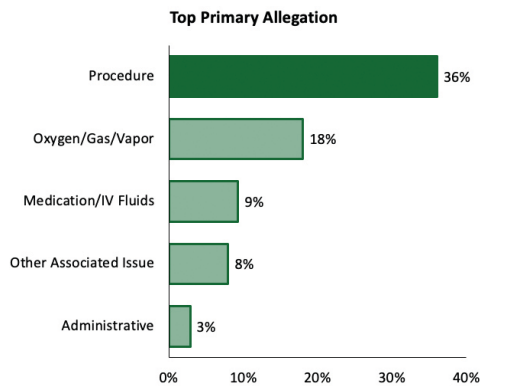


Disposition	Anesthesiology	All Specialties
Verdict-Plaintiff	\$1,045,589	\$750,427
Alternative Dispute Resolution	\$406,202	\$302,938
Settled	\$394,268	\$347,601
Early Offer	\$138,486	\$178,838

Top Allegations in Anesthesiology Claims

The most common primary allegation was procedure, making up 36% of closed claims. 47% of all specialty closed claims had procedure as their primary allegation.

The only allegation unique to Anesthesiology was Oxygen/Gas/Vapor, which was less common among all specialties.



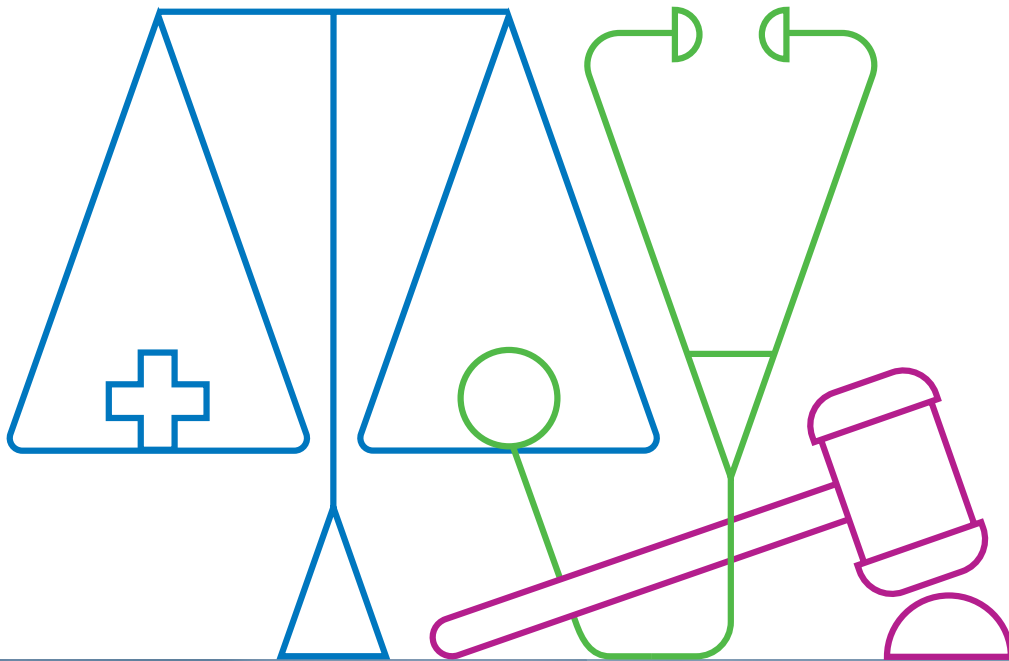
Primary Allegation	Closed Claims	%
Procedure	1361	36%
Oxygen/Gas/Vapor	680	18%
Medication/IV Fluids	351	9%
Other Associated Issue	301	8%
Administrative	108	3%

Data on this page is from the Data Sharing Project Dashboard.
MPL Specialty Snapshot (2012-2021). MPL Association.
Retrieved by ProAssurance (January 24, 2024).

MEDICAL MALPRACTICE CLAIMS DEFENSE

Every action we take in your defense is guided by our mission to protect others. Our proudest achievement is the sheer volume of claims we've been able to close without indemnity and without going to trial.

In addition to working for you in and out of the courtroom, we also work tirelessly to be an advocate for medical professionals when it comes to legislation and tort reform that may impact your practice of medicine.



5-Year ProAssurance National Claims Summary, 2020-2024*

19,900+

open malpractice claims managed by ProAssurance.

96.6%

of closed claims resolved without going to trial.

77.0%

of claims closed without indemnity (no money was paid to the plaintiff).

*These numbers represent medical malpractice claims from 2020 to 2024 extracted from the ProAssurance MPL claims reporting system.

Through the use of tailored risk management services that address the real world application of anesthesia risks, ProAssurance aims to reduce risk and provide better patient safety outcomes to avoid claims before they become a lawsuit.

“Our internal data shows that when anesthesiologists are able to put proper risk management protocols in place, there are usually fewer claims, and the claims are often less severe.”

Mallory B. Earley, JD, CPHRM

Assistant Vice President, Risk Management

“ProAssurance risk management resources are developed using closed claims data and validated industry data.

Our goal is to identify risks and keep our physicians out of the courtroom and in the operating room.”

Mallory B. Earley, JD, CPHRM

Assistant Vice President, Risk Management

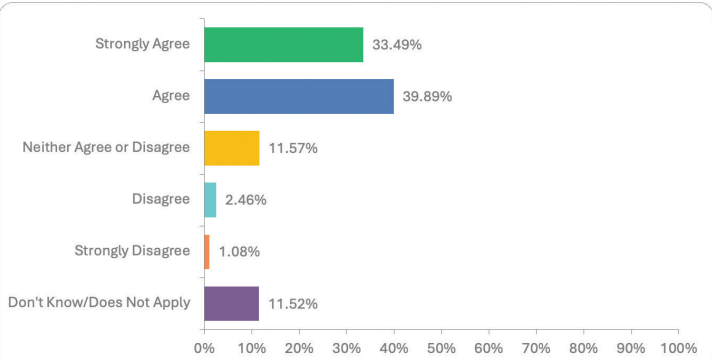
ANESTHESIA ANNUAL BASELINE SELF-ASSESSMENT DATA

The ProAssurance Risk Management department launched the Annual Baseline Self-Assessment (ABSA) in 2024, with anesthesia questions to identify areas of risk in the practice through surveying both physicians and medical staff. Here is a sneak peek of a few questions and early results from Q1 and Q2 2024. These questions and charts would be compiled in a full report to share with the practice to show how they answered in comparison to these overall benchmarks. A ProAssurance Risk Management consultant would create a tailored plan and distribute it to the practice with educational resources to improve identified areas of concern.

ABSA Data and Anesthesia-Specific Questions

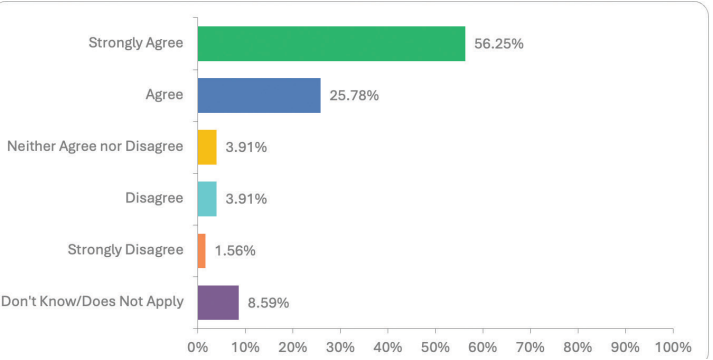
Question:

Everyone is willing to report deviations from protocol they observe.



Question:

Licensed staff are trained to respond to emergent patient conditions arising during and after the procedure.



ProAssurance successfully deployed the standard ABSA question set in early 2024, and we are currently developing specialty-specific tools to address specialty-specific risks. Anesthesia organizations often lack the scope for general practice-based questions and can be better served answering tailored questions that are relevant only to Anesthesiology. The Risk Management team launched an additional Anesthesia-specific tool in the third quarter of 2024, and we have a limited number of completions at this time. Below is a sample of those Anesthesia-specific questions.

Sample Anesthesia ABSA Questions

- The risks of dental damage during intubation are discussed as part of the anesthesia informed consent process, and the discussion is documented in the medical record.
- The organization has a policy that outlines the process for screening patients' pre-anesthesia medical co-morbidities.
- Anesthesia participates in the surgical time-out, and it is documented in the medical record.
- Post-anesthesia evaluations are completed within 48 hours after surgery or an anesthesia procedure and are documented in the patient's medical record.

Since the 2024 launch of the ABSA,

3,065

self-assessments were taken by staff at

511

practices to evaluate medical liability risk management knowledge gaps.

These numbers were extracted from 2024 ProAssurance medical professional liability risk management data.

The immediate objective of the ABSA is to find and address current gaps within the individual practice, and there will be benchmarking benefits over time. The aggregate data will allow insureds to compare their practice to others based on specialty, location, group size, and more. The annual nature of the program will allow them to see progress over time.

ANESTHESIA RISK MANAGEMENT SERVICES



Annual Baseline Self-Assessment (ABSA)

The ABSA is a brief survey that can be completed by the entire healthcare team (physicians included) in a few short minutes. Questions focus on office processes related to medical liability. This approach promotes candid answers to help us identify gaps in knowledge. Aggregated results are then reviewed so that focused educational opportunities can address the gaps. With a better understanding of what puts a practice at risk, we can improve defensibility in the event of a claim.



To request the ABSA, scan the QR code.

Risk Management Guidelines

The *Risk Management Guidelines* are a first-stop resource for your risk questions. This can help make it easier for you to meet day-to-day challenges and facilitate implementation of long-range loss prevention strategies. These guidelines are a resource to promote patient safety, minimize risk, and improve defensibility of claims by providing resources to physicians, administrators, and healthcare staff.

Topics cover:

- Incident & Claim Reporting
- Communication
- Disclosure of Adverse Events
- Informed Consent
- Medical Records
- Protected Health Records
- Tracking Systems
- Policy & Procedure Manuals
- Natural Disasters
- Emergency Medical Plans
- Ending the Physician-Patient Relationship
- Contingency Planning
- Office Staff
- Telemedicine



To review the *Risk Management Guidelines*, scan the QR code.

2,800+

contacts were made with a ProAssurance Risk Management consultant by Helpline or email.

These numbers were extracted from 2024 ProAssurance medical professional liability risk management data.



Anesthesia Malpractice Case Studies

By presenting actual case histories of malpractice claims, malpractice case studies are intended to help physicians recognize some of the common causes of malpractice claims.



Scan for Anesthesia-specific case studies, scan the QR code.

Anesthesia Risk Management Education

Risk Management provides quality education for physicians, advanced practice providers, practice managers, and staff through online seminars and live virtual webinars often carrying CME credits. Additional educational resources include risk management guidelines, 2-minute videos, Rapid Risk Review podcast, sample forms, and text-based CME publications. No matter the level of time commitment, ProAssurance has an educational offering to fit everyone.

Consultation with Risk Management Consultants

The ProAssurance Risk Management department is here to help you promote patient safety, minimize risk, and improve defensibility of claims by providing comprehensive assessment and training resources that are relevant and easy to share.

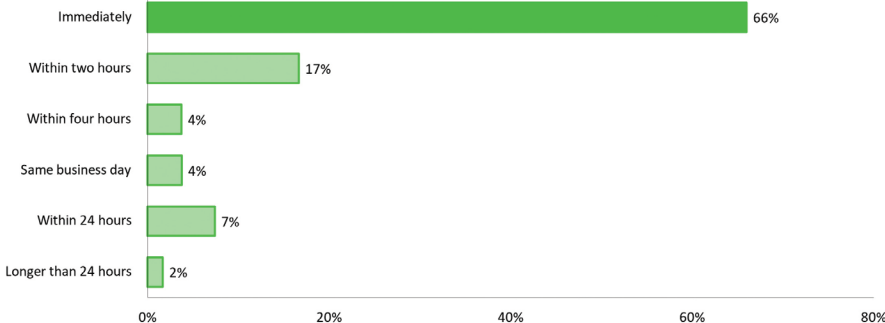
Your physicians, administrators, and healthcare staff have access to a team of risk consultants with a wide range of backgrounds, including prior experience as healthcare administrators, attorneys, nurses, and quality professionals. Risk consultants assist insureds with their liability concerns and questions using specialized knowledge of healthcare risk management issues and the Company's experience defending claims.

Helpline: 844-223-9648

Monday through Friday, 8 a.m. – 5 p.m.

Email: RiskAdvisor@ProAssurance.com

2024 Helpline Response Times Distribution for Q2 2024



HELPING ANESTHESIOLOGISTS

- Minimize exposure
- Maximize defensibility
- Practice with confidence

We consider all cases seriously, and if our insured receives notice of a potential claim, we provide experienced malpractice counsel, bringing clarity developed on a national scale to the anesthesia claims process.



ProAssurance.com

